CHAPTER 4

Post-acute care providers

RECOMMENDATIONS

Section 4A: Skilled nursing facility services

4A-1 The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2007.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

4A-2 The Secretary should modify the PPS for skilled nursing facilities to more accurately capture the cost of providing care to different types of patients. This new system should:

- reflect clinically relevant categories of patients;
- more accurately distribute payments for nontherapy ancillary services;
- improve incentives to provide rehabilitation services based on the need for therapy; and
- be based on more contemporary, representative data than the current system based on time study data from 1990, 1995, and 1997.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

4A-3 To improve quality measurement, the Secretary should:

- collect information on activities of daily living at admission and at discharge;
- develop and use more quality indicators, including process measures, specific to short-stay patients in skilled nursing facilities; and
- put a high priority on developing appropriate quality measures for pay for performance.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

Section 4B: Home health services

The Congress should eliminate the update to payment rates for home health care services for calendar year 2007.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

Section 4C: Long-term care hospital services

The Congress should eliminate the update to payment rates for long-term care hospital services for 2007.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

Section 4D: Inpatient rehabilitation facility services

The Congress should eliminate the update to payment rates for inpatient rehabilitation facility services for fiscal year 2007.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

CHAPTER 4

Post-acute care providers: An overview of issues

Chapter summary

The recuperation and rehabilitation services that post-acute care providers furnish are important to Medicare beneficiaries. Medicare beneficiaries can seek care after a hospitalization in four different post-acute care settings: skilled nursing facilities (SNFs), home health agencies, long-term care hospitals (LTCHs), and inpatient rehabilitation facilities (IRFs).

Medicare's goal is to ensure that beneficiaries receive appropriate, high-quality care in the least costly setting consistent with their clinical conditions. Starting with this premise, we see two key problems as we look across post-acute care settings. One is the lack of integration and coordination of policies across settings. The other is limitations (though not always the same ones) in the performance of the distinct post-acute care payment systems that Medicare uses for these settings.

This year, the Commission analyzed payment adequacy for each of the four types of post-acute care providers. These analyses and our prior work on comparability of post-acute care settings reveal similar issues

In this chapter

in all of the payment systems for these providers. Before describing each analysis, we lay out these common themes:

- Payments are not accurately calibrated to costs.
- Services overlap among settings.
- The post-acute care product is not well defined.
- Assessment instruments differ among settings.

New prospective payment systems (PPSs) for post-acute care providers have led to changes in the patterns of post-acute care use. The Centers for Medicare & Medicaid Services (CMS) developed a PPS for each type of provider, following mandates in the Balanced Budget Act of 1997 (BBA).

Providers have responded to the new incentives of the PPSs in ways that may not serve the program or beneficiaries well. For example, the Commission has documented changes in the mix of services provided and patients served, which may result from the incentive to select patients who will be cared for most profitably. These responses have led us to call for refining the case-mix systems, measuring quality of care, and better defining the characteristics of the care that should be provided in each setting.

The Commission has recommended that CMS refine the system for SNFs because of concerns that the payment system systematically pays too much for some types of patients and too little for others. Inaccurate case-mix systems in general create incentives for providers to select patients for whom profits are highest, to the detriment of other patients and the providers who serve them. However, even under refined case-mix systems that would better match payments to patients' resource needs, patient characteristics not in the case-mix systems would still likely affect how profitable a given type of patient would be to providers, creating an incentive to select patients. Including these characteristics may not always be possible or even good policy. Collecting the information needed may be too burdensome or including the information may create perverse incentives in treatment.

Refinement would also not eliminate the potential for selection within each case-mix category.

The types of services and patients seem to overlap among settings, creating further opportunities for providers to benefit from selecting patients. The settings with higher payments from Medicare will find it easier to generate referrals from physicians if they offer more specialized care, which patients may not always need. This is not to say that all patients overlap; some patients are clearly best suited for some settings. It is at the margin that we see apparent similarities among patients. Even if there are overlaps in some patients, whether the settings are substitutes—that is, providing the same level of care—or complements is unknown.

The product Medicare is buying from each setting is not always clearly defined or measured, and the way care is delivered varies within each type of setting. The lack of clear product definitions makes both accurate pricing and quality measurement difficult. Further, because the product is not well understood, it is unclear whether a low-cost provider is stinting or efficient. Better measures of quality and outcomes are needed to address this issue. Ideally, Medicare should identify the type of care that patients need, not the type of setting.

Each setting also has different patient assessment tools, complicating comparisons of cost and the quality of patient outcomes across settings. Long-term care hospitals have no standard patient assessment tool at all, although providers have developed their own for care planning. CMS uses setting-specific patient assessment tools to determine payment rates within each of the other three systems, and quality measures are also derived from the assessment in each setting.

Refining all of the case-mix systems would not resolve issues of whether patients go to the lowest-cost, appropriate post-acute setting or whether they need post-acute care at all. Some patients might recover and recuperate at home using outpatient settings or might do best by staying a few more

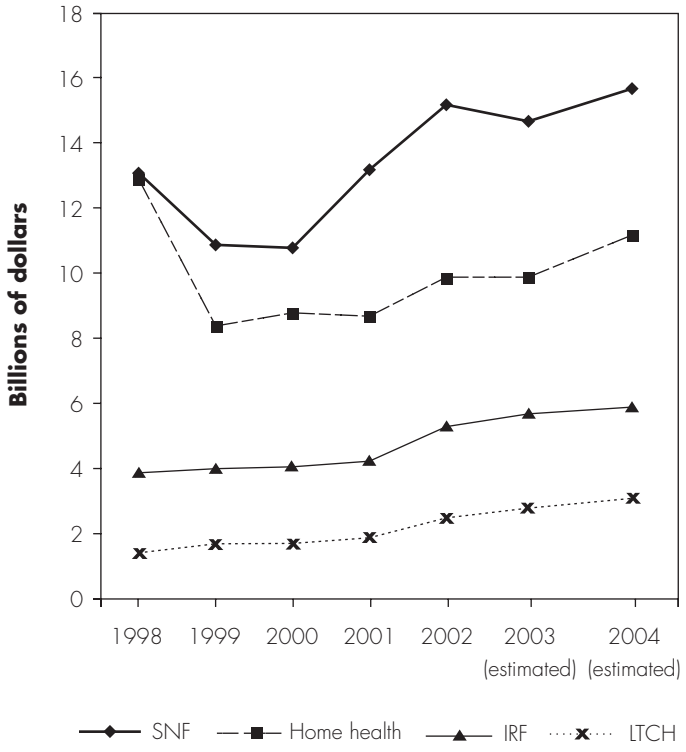
days in the acute-care hospital. Medicare would also want to make sure that beneficiaries receive the most clinically appropriate and effective care, regardless of the setting.

To this end, the Commission is looking beyond the payment adequacy question in each setting to think more broadly about how to match patients who use post-acute care with the set of services that can provide the best outcomes at the lowest cost. One approach would develop tools to compare patients across post-acute care settings; another would think of more integrated approaches. The Commission has not yet identified a strategy but hopes to develop these ideas in future work. Recent legislation establishes a demonstration of a common assessment instrument and explores issues of cost across settings in 2008. ■

Medicare beneficiaries can seek care after a hospitalization in four different post-acute care settings: skilled nursing facilities (SNFs), home health agencies, long-term care hospitals (LTCHs), and inpatient rehabilitation facilities (IRFs) (see text box on p. 158 for an overview of each of these settings). Clear and comprehensive criteria are lacking for what type of post-acute care is best for patients with particular characteristics or needs. Although Medicare defines eligibility for each setting, these definitions do not clearly delineate which patients should go to which setting for which services. Further, the payment systems for these settings and their patient assessment tools have developed separately over the years, each based on its own historic costs and care patterns.

The Commission maintains that in the post-acute care sector, just as in the other sectors of Medicare, the services provided should meet beneficiaries' needs, Medicare payments should cover an efficient provider's costs of furnishing appropriate services, and the program should reward higher-quality care. Because of the overlap in services and patients among post-acute care providers, we may also want to consider efficiency across post-acute care and not just within each setting. However, the lack of comparable patient assessment instruments confounds our ability to judge efficiency and quality across settings. The sections that follow focus on payment adequacy for each setting, using the framework laid out in Chapter 2. We also discuss the particular issues that we see in each setting. In some cases, we offer recommendations to improve payment or quality measurement within the setting.

FIGURE 4–1 **PAC spending shows recent growth**



Note: PAC (post-acute care), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility), LTCH (long-term care hospital). These amounts are program spending only; they do not include beneficiary copayments.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary.

Background

Medicare spending on post-acute care services totaled about $36 billion in 2004, accounting for more than 12 percent of total Medicare spending. After slowing in the late 1990s when CMS implemented the Balanced Budget Act of 1997 (BBA), spending and the number of providers have risen (Figure 4-1). The number of home health agencies increased by 10 percent in the last year alone, and there were over 50 percent more LTCHs in 2005 than in 2000. The rise in spending is the result of both higher payments and greater use.

In 2002, about one-third of Medicare beneficiaries discharged from prospective payment system (PPS) hospitals went to a post-acute care setting. About one-third of those went to a SNF, one-third to home health, and the rest to other settings (for example, IRF) or several settings (for example, SNF followed by home health care). Post-acute care use is not uniform, either across or within the diagnosis related groups assigned in the hospital. For some conditions, such as angina and chest pain, few beneficiaries use post-acute care services. For others, including major joint procedures, stroke, and tracheostomy, these services are commonly used. But even for these conditions, some beneficiaries do not use post-acute care.

The last era of rapid growth in post-acute care in the late 1980s and early 1990s was spurred by a number of factors: the profitability of SNF and home health services under cost-based reimbursement and payment for each unit of care, the loose eligibility requirements, and the poor oversight of program integrity. These increases also may have been encouraged by hospitals' incentives to shorten length of stay in the hospital. In the Balanced Budget Act of 1997, the Congress mandated that CMS develop

Who are the post-acute care providers?

Skilled nursing facilities (SNFs)

Medicare covers care in a skilled nursing facility when a patient meets two conditions. First, the patient requires daily skilled nursing or rehabilitation staff to manage, observe, and evaluate care. Examples of skilled care are changing dressings and physical therapy. Second, the patient had a prior hospital stay of at least three days within 30 days of admission. Patients have no cost sharing for SNF care through the first 20 days of a stay. For the next 80 days, patients must pay a daily copayment. After 100 days, Medicare coverage ends, and other insurers, patients, or the Medicaid program pays for any additional days of care.

A skilled nursing facility could be part of a nursing home or a hospital. Medicare certifies these facilities if they have the staff and equipment to give skilled nursing care or skilled rehabilitation services. More detail on SNFs and the payment system is available at http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_SNF.pdf.

Home health agencies

Home health care includes skilled nursing, therapy, aide services, or medical social work services provided to beneficiaries in their homes. To be eligible for Medicare's home health benefit, beneficiaries must need part-time (fewer than eight hours per day) or intermittent (temporary but not indefinite) skilled care to treat their illness or injury and must be unable to leave their homes without considerable effort. Daily care is precluded except on a short-term basis. Home health care has no coinsurance or cost sharing.

Home health agencies may be freestanding or based in another type of health care facility (hospital, nursing home, or inpatient rehabilitation facility). Regardless of where they are based, home health agency staff travel to furnish all care in the beneficiaries' home. More detail on home health agencies and the payment system is available at http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_HHA.pdf.

Long-term care hospitals (LTCHs)

Patients use long-term care hospitals as they would an acute care inpatient hospital; the distinction is the length of stay. Long-term care hospitals are certified as hospitals and are intended to treat medically complex patients with long lengths of stay. Medicare requires that the average Medicare length of stay be more than 25 days (the average length of stay in hospitals under the acute care inpatient PPS is approximately 5 days). Cost sharing and coverage follow the acute care hospital rules.

The characteristics of long-term care hospitals vary. Some are converted from former public health hospitals; these tend to have the most beds and are concentrated in New England. Newer entrants, called "hospitals within hospitals," are located on the same grounds as an acute care hospital but have separate ownership and financial arrangements. Hospitals within hospitals are smaller than the older LTCHs. Despite a reputation for serving ventilator patients, long-term care hospitals serve a wide mix of patients, including those requiring wound care and those with respiratory and other infections.

LTCHs are usually the most costly post-acute setting for Medicare beneficiaries. The Commission has found that, while LTCH patients generally cost Medicare more than similar patients using alternative settings, the cost is comparable for the sickest patients. Detail on long-term care hospitals and the payment system is available at http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_LTCH.pdf.

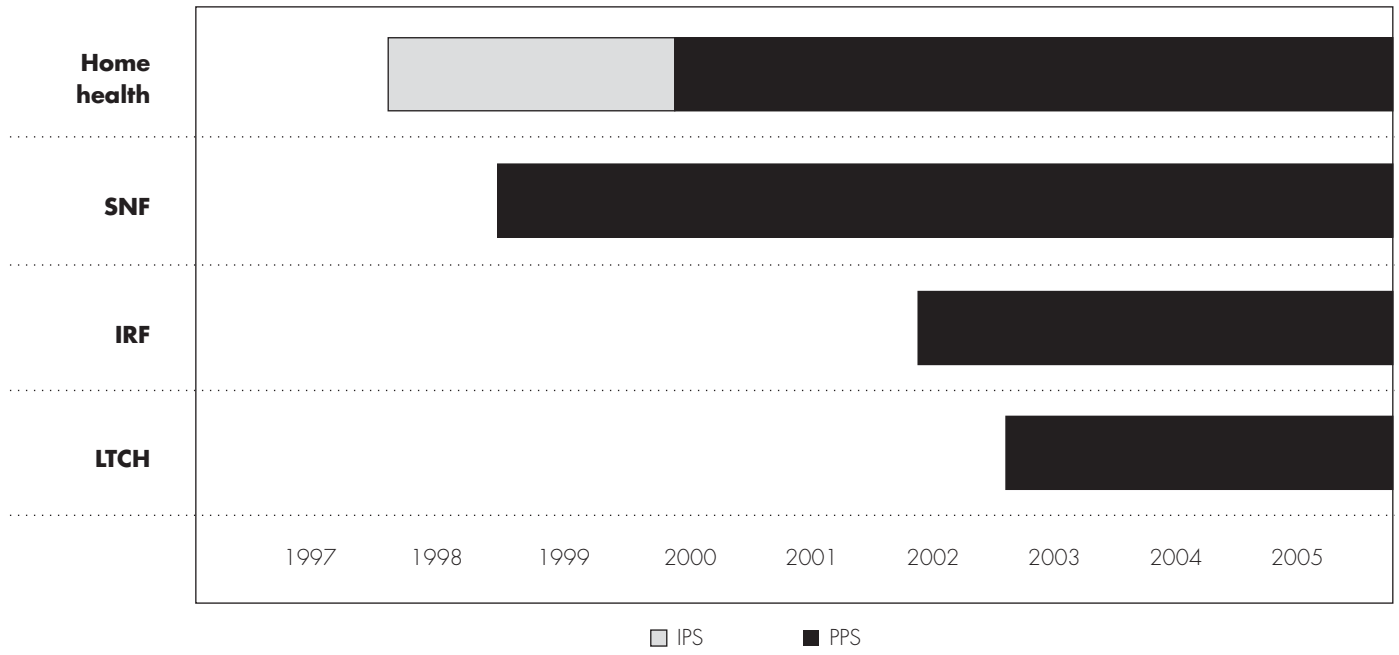
Inpatient rehabilitation facilities (IRFs)

Inpatient rehabilitation facility care is provided to patients who can sustain three hours of therapy per day. In contrast to the other post-acute care settings, IRFs are directed solely toward rehabilitation rather than recuperation. Cost sharing and coverage follow the acute care hospital rules.

Although inpatient rehabilitation facilities are certified as hospitals, they must meet several additional requirements. At least 75 percent of their patients must fall within a select list of diagnoses that CMS finds most indicative of the need for IRF care (This issue is discussed in more detail in Chapter 4D). Most IRFs are hospital based although freestanding rehabilitation hospitals also participate in Medicare. More detail on inpatient rehabilitation facilities and the payment system is available at http://www.medpac.gov/publications/other_reports/Dec05_payment_basic_IRF.pdf. ■

FIGURE 4–2

Post-acute care PPS starting dates



Note: PPS (prospective payment system), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility), LTCH (long-term care hospital), IPS (interim payment system).

prospective payment systems for each of these settings in the hope of curbing the rapid increase in post-acute care spending. Figure 4-2 shows the implementation dates for each of the new PPSs.

Cross-cutting issues in post-acute care

This year, the Commission has conducted payment adequacy analyses for each of the four types of post-acute care providers. We find many similarities in the experiences with the payment systems for these providers; before we describe each payment adequacy analysis in the following sections, we lay out several common themes.

Experience under the prospective payment systems

New PPSs for post-acute care providers have led to changes in the patterns of post-acute care use. CMS developed a PPS for each type of provider, following mandates in the BBA. The Congress intended the prospective payment systems to moderate spending, as had the earlier prospective payment system for inpatient hospital care. In two of the most frequently used post-acute care settings, payments slowed following the BBA but have started to rise again. At the same time, providers have responded to the incentives of the PPSs in ways that may not serve the program or beneficiaries well. For example, the Commission has documented changes in the mix of services provided and the types of patients served that have resulted in very high margins. The PPSs also give providers an incentive to select patients who will be cared for most profitably under the new system. These responses have led us to call for action to slow payments, refine the case-mix systems, and measure quality of care.

Changes in the pattern of care following introduction of a new PPS are to be expected. Under the inpatient PPS, hospitals changed the hospital product by shortening length of stay, which led to high hospital inpatient margins and fueled the growth in post-acute care. Medicare payment policy also has changed to reflect the new patterns of care. For example, the transfer policy pays hospitals proportionately less for patients whose length of stay is at least two days shorter than average and who go to post-acute care settings. The Commission has recently called for the Congress and CMS to refine the hospital case-mix system to reduce incentives to select certain

types of cases or less severely ill patients (MedPAC 2005c).

One example of the response to the incentives of the new prospective payment systems is in SNFs. The SNF prospective payment system contains strong incentives for facilities to provide therapy. While this method of paying for therapy counters incentives in any PPS to stint on services, there is currently no way to measure whether patients are benefitting from the therapy they receive. So under the current system, SNFs that provide additional therapy will earn higher payments even if their patients do not benefit from additional therapy.

Another example of response is in home health. The Commission has documented the dramatic drop in the number of visits provided during a 60-day episode of care. In the previous payment system, home health agencies earned more revenue with each visit they made. Under the interim payment system of cost limits and under the PPS, the incentive is to provide fewer visits within the episode of care, because the payment does not vary with the number of visits (unless the number of visits is so low as to trigger a low-utilization payment). Measured quality has not suffered from the lower number of visits.

We find that financial performance varies widely among providers. While this is not unexpected given differing market conditions and management decisions, some of the variation may be because of case-mix systems that systematically pay too much for some types of patients and too little for others. Inaccurate case-mix systems in turn create incentives for some providers to select patients for whom profits are highest, to the detriment of other patients and the providers who serve them. The lack of a clear definition of the standard of care we expect from the service contributes to the problem because providers can furnish fewer services than average and profit from the system. The payment systems for two settings—SNFs and home health agencies—reward rehabilitation over other important care also provided in those settings. Medicare should pay adequately for rehabilitation but not by creating a bias against treating patients with complex medical needs who do not also need therapy.

Even under refined case-mix systems that better match payments to patients' resource needs, patient characteristics not in the case-mix systems would likely still affect how profitable a given type of patient is to providers, creating an incentive to select patients. Including these characteristics may not always be possible or even a good policy. Collecting the information needed may be too burdensome. Adjusting payment based on some patient characteristics would create perverse incentives. For example, home health patients who have caregivers at home receive fewer visits than those who do not. But paying home health agencies less for patients with caregivers at home might discourage agencies from caring for patients with such informal care, which in turn might discourage family members and others from providing this support.

In the SNF prospective payment system, the Commission and others have identified several flaws that may lead to overpayment of some cases: lack of adjustment for nontherapy ancillary services, higher payment for more therapy, and case-mix weights based on outdated time-study data collected before the implementation of the PPS. Recommendation 4A-2 addresses this issue.

Analysts familiar with the home health PPS have drawn attention to possible problems with the case-mix system as well, although other observers have stated that the key problem in the home health care payment system is that the services are undefined. The results of the Commission's recent analysis were not strong enough to draw a conclusion about the accuracy of the payment system, although growth in rehabilitation episodes suggests that these services are profitable (MedPAC 2005a).

Overlap in services and patients among settings

Overlaps in the types of services and patients create opportunities for selection of patients among settings—with incentives for patients to go to the settings where they can be most profitably treated, not necessarily where they need care. Decision makers lack criteria to determine the choice of setting objectively, and Medicare does not know whether patients are receiving quality care in the lowest-cost setting.

All four post-acute care settings provide rehabilitation and recuperation. For example, patients with joint replacements might go home with home health care or outpatient therapy, to a SNF, or to an inpatient rehabilitation facility upon leaving the hospital. Patients with complex medical conditions (e.g., patients who need tube feeding or respirator care) may go to an LTCH or a SNF, or they might stay longer in the hospital. Hospital discharge planners and physicians make judgments about where patients should go based, in part, on coexisting

conditions and family and housing circumstances. However, they have no evidence-based criteria to help them sort where patients should go or what care they should receive. Medicare also has no way of knowing when patients are getting quality care at the most efficient setting for their needs. Medicare's attempts to define eligibility for patients to use certain settings leave much to the providers' discretion.

Discharge planners and physicians decide where a patient should go based on the community's available resources; physicians' perceptions of post-acute care providers' capabilities and quality; the patient's preferences, health status, and ability to improve in the setting; and the payment system's incentives. Some of these factors may be susceptible to providers' influence. For example, if Medicare pays more for patients in one setting than in another, providers in the higher-paid setting may develop capabilities to attract those patients. A facility may also develop relationships with physicians and discharging hospitals (particularly likely when they are located in the same hospital) that will draw more patients to the higher-paid setting. Over time, patients whose need is less clear may tend to go to the higher-paid facility, and Medicare thus would pay more than is necessary for their recovery and recuperation.

Long-term care hospitals are only available in some parts of the country, raising questions about where the kinds of beneficiaries treated in LTCHs receive care in parts of the country without these facilities.

We have some limited information about differences in outcomes based on particular conditions and settings. Research for the Commission compared cost and outcomes for patients with lower extremity joint replacement in three settings—the SNF, IRF, and home (Beeuwkes Buntin 2005). This study found that the IRF was the most expensive setting for Medicare and that the outcomes (though the differences were not large) were best for patients who went home. Those who went to an IRF had worse outcomes than those who went home, but better outcomes than those who went to a SNF. This study's analysis was limited in the types of outcomes and by the lack of comparable patient functional status measures among the settings.

Although this study used sophisticated techniques to control for selection, the finding that patients who returned home had the best outcomes suggest that unmeasured selection is still present in the data. Although some patients may recover best without any institutional care, one would expect that the patients who go home are the least ill and their better health status accounts for their better outcome. Other researchers have also looked at the question of substitution across post-acute care settings and attempted to measure differences in outcomes. The findings are mixed on this question, and the results differ by patient diagnosis (MedPAC 2005b).

In two post-acute care settings, CMS and the Commission have made or called for specific policy changes to mitigate the potential for patients to use higher-cost settings unnecessarily. For example, CMS has changed the types of cases that qualify a facility as an inpatient rehabilitation facility (as opposed to a short-stay hospital) due to concerns about patients using IRFs when another post-acute care setting would provide comparable care at lower cost to the program. The Commission has called for a new, clearer definition of LTCH care to help limit use of this costly type of care to the patients who will benefit the most from it. Specifically, we recommended that the Congress and the Secretary develop facility and patient criteria to make sure that the patients who are admitted to these facilities are medically complex and have a good chance for improvement (MedPAC 2004). Facility-level criteria would include staffing, patient evaluation and review processes, and mix of patients. Patient-level criteria would include clinical characteristics (such as open wounds) and treatment modalities.

Lack of clarity in the product Medicare is buying from post-acute care settings

The product Medicare is buying from each setting is not always clearly understood. The pattern of care is changing under the PPSs in response to the new incentives. The lack of clear definition of the product makes it difficult to know whether the change in care represents gains in efficiency or a perverse outcome.

The lack of a defined product allows the capabilities of post-acute care providers to vary from market to market. For example, a SNF in one city may have different capabilities than one in another city; indeed the capabilities of SNFs to care for certain patients may vary within a city. In some instances a SNF may be a ready substitute for an LTCH, even for relatively complicated patients; another SNF may not be.

In addition, the purpose of the home health benefit must be the same as the general purpose of all the services covered by the Medicare program: diagnosis or medically

necessary treatment of illness, injury, or deformity over a spell of illness. However, precisely how the concepts of medical necessity and spell of illness pertain to home health is less clear than it is for facilities. Like other post-acute care settings, home health has no definitive clinical practice standards to determine what treatments are necessary and for what kinds of patients they are appropriate. The range of services covered by home health is fairly broad: skilled services necessary to treat patients—nursing and therapy—as well as nonskilled or nonmedical services that are necessary to maintain patients' health or facilitate their treatment—aide services and social work.

Differing patient assessment tools across settings

The differences in the assessment tools across post-acute care settings make it difficult to compare costs and outcomes across settings. Ideally, patient assessment tools would help providers assess patients' care needs and evaluate patient outcomes and the quality of care. While Medicare requires three of the post-acute care settings to use patient assessment tools, each uses a different one. SNFs use the Minimum Data Set (MDS), home health agencies use the Outcome and Assessment Information Set (OASIS), and IRFs use the IRF–Patient Assessment Instrument (IRF–PAI). Medicare does not require LTCHs to have a patient assessment tool. Uniform information would allow researchers and program administrators to compare costs, quality, and other outcomes across post-acute care settings, while controlling for differences in patient condition and other characteristics.

The Commission has found that although the tools measure the same broad aspects of patient care—functional status, diagnoses, comorbidities, and cognitive status—the timeframes covered, the scales used to differentiate among patients, and the definitions of the care included in the measures vary considerably (MedPAC 2005b). These differences make it very difficult, if not impossible, to compare care across settings and conclude which setting is the most efficient and effective for similar patients.

Toward a more integrated approach to post-acute care

The problems we discuss in the previous section reinforce each other—poor case-mix systems create incentives for selection within and among settings, lack of clear criteria allows some high-cost facilities to serve patients who might benefit just as much from a lower-cost setting, and poor quality information makes it difficult to develop better criteria. These interwoven problems led us to look at alternatives to the current payment approach, which bases payment on the setting rather than on the care the patient needs. These alternatives are only conceptual at this point. Because of complex problems in implementing these ideas, which we discuss below, they will need more thought before the Commission is prepared to recommend them.

The goal of an integrated approach to post-acute care is for patients to go to the post-acute care settings that can provide the best outcomes at the lowest cost to Medicare. We discuss two approaches to this end. One focuses on developing a common assessment instrument to be used in all settings. The second approach is for Medicare to designate a case manager for post-acute care.

The Commission has not yet developed recommendations in these areas and plans to explore these ideas in future work. While the Commission supports the goals of a comprehensive data collection approach and payment policy, developing these approaches is not easy in the near term and would likely require significant resources.

Recent legislation establishes a post-acute care demonstration by 2008 that would be designed to understand costs and outcomes across different post-acute care sites. Under this program, patients with certain diagnoses will receive a single comprehensive assessment on the date of discharge from an inpatient hospital to determine their needs and the clinical characteristics of their diagnosis to determine their appropriate placement in a post-acute care site. CMS will develop and use a standardized patient assessment instrument across all post-acute care sites to measure functional status and other factors during the treatment and at discharge from each provider. Participants in the program will provide information on the fixed and variable costs for each individual. An additional comprehensive assessment will be provided at the end of the episode of care.

Tools to develop better information on post-acute care

To help address the problem of measuring the value of post-acute care services furnished to Medicare beneficiaries, the ideal is a common patient assessment tool that would be used in every post-acute care setting

so that we can compare costs, quality of care, and patient outcomes, while controlling for differences in patient condition and other characteristics that should affect the content and cost of care or the patient's capacity to benefit from care. However, for reasons noted last year, none of the currently used tools is the best starting point for this purpose, though elements of each might be modified (MedPAC 2005b). Developing this tool probably would take time and considerable resources. A shorter-term approach might be a tool that doctors and discharge planners would use to assess patients before sending them to post-acute care.

An adequate common patient assessment tool would require each post-acute provider to collect the same information. Consistent information would allow us to know what Medicare is buying in each setting, evaluate the value of the services furnished, and consider which patients are appropriately treated in each setting. For providers, the information gathered from the patient assessment tool should help them assess patient outcomes and the quality of care.

The burden of developing a common patient assessment tool and collecting the data to support it might be high, particularly during the transition to the new instrument. Existing payment systems and quality measures may also need to be revised to reflect the new instrument.

In the shorter term, one might focus on developing a decision tool to help discharge planning and admission assessment that would help sort patients into post-acute care based on their clinical needs. However, to develop this assessment decision tool, we need more research that systematically compares the cost, quality, and patient outcomes of alternative settings for specific patient conditions. Ideally, this assessment would evaluate the patients' current and expected care needs and then identify the services required to meet those needs. Hospital staff or a physician would use this decision tool before patients are discharged from the acute care hospital to inform them in deciding to which post-acute care setting (if any) the patients should go. A referring physician could also use this tool for patients without a prior hospitalization.

CMS is taking steps to develop information to improve post-acute care. A contractor will identify the data hospital discharge planners should use to make appropriate patient placements; recommend quality measures; and review patient assessment tools, classification systems, and care management systems. CMS will also use an umbrella instrument to gather some new information and to house summarized data from each setting's existing patient assessment tool.

Rationalizing post-acute care

The Commission is also beginning to explore longer-term ideas for improving the incentives in the post-acute care system. One approach would be similar to the chronic care initiative that CMS is now testing in a pilot project. This program identifies patients based on their health care conditions in Medicare claims and then assigns them to a care manager or nurse advisor, who helps provide information to patients and their physicians. A similar approach would be for Medicare to pay for case management for post-acute care patients, identifying them while they are still in the hospital. Medicare could pay a case manager a fee to help direct these patients to the setting where they would have the services that best meet their needs. Case management could include performance risk as in the Medicare Health Support initiative. Under this model, the case management fees are at risk—providers must pay them back if they do not achieve spending and quality targets. Alternatively, a case management entity could take risk for post-acute care benefits in a type of capitation arrangement where the entity would then pay post-acute care providers directly. Because an at-risk care manager would profit from sending patients to low-cost settings, this idea creates the challenge of holding the care manager accountable for the quality of care and the need to monitor care so patients receive the care they need. It also raises the question of how to decide which patients would go to post-acute care and which would receive similar outpatient services.

We see other challenges in implementing either of these approaches. First, not all patients enter a SNF, home health agency, IRF, or LTCH from the hospital: At least half of home health care patients are referred from the community. Second, a lack of assessment and discharge planning tools, together with a lack of evidence-based outcome information across settings and patients, would hamper private entities just as they hamper the program. Third, the amount of resources needed to develop these tools, accommodate payment systems, and tie quality measurement to them is another set of challenges. Fourth, ceding the decision of where to refer patients to a third party would represent a shift in power from providers to the entity. Post-acute providers would likely resist being beholden to a case manager in this way. ■

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